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Physicians' new letter

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Flu Shots

Influenza vaccine was made available mid-October 2003. A physician recommendation for influenza immunization is the most significant factor in a patient's decision to be immunized. Encourage the patients in your care to get immunized against influenza.

Influenza vaccine is provided free to people 65 and over; adults and children with chronic health conditions; independent health care practitioners (e.g. doctors, nurses, and dentists) and their staff; staff and residents of care facilities; emergency responders (police, fire and ambulance workers); and corrections officers. For a detailed listing of eligible recipients, review section 7, page 31 of the BCCDC Immunization Manual at this web site: http://bccdc.org/content.php?item=83#1

Influenza season is also an opportune time to provide the pneumococcal polysaccharide vaccine to patients. This vaccine is provided free to people 65 and over; adults and children with chronic health conditions; and residents of care facilities. For a detailed listing of eligible recipients, review section 7, page 43 of the BCCDC Immunization Manual at this web site: http://bccdc.org/content.php?item=83#1

Flu shots should be billed under fee item 00010 (intramuscular medications) for any person eligible to receive the free influenza vaccine. A visit fee should not be billed if the flu shot was the sole reason for the visit.

Only those persons eligible for publicly funded vaccine should have their flu shots billed to MSP. Charging an eligible person, for either the vaccine (serum) or the injection, is in contravention of the *Medicare Protection Act* Part 4 Section 17(1).

British Columbia Medical Association
Leading Diabetes Collaborative

The British Columbia Medical Association is pleased to announce that it will be commencing participant recruitment for its *Province-Wide Diabetes Collaborative* in November 2003. The collaborative activities will start early 2004.

This innovative professional development initiative, designed in collaboration with BC's health authorities, will assist practitioners to organize their clinical practice for optimal management of chronic diseases with a special emphasis on diabetes care.

How Does A Collaborative Work?
The Collaborative takes place over a 12-18 month period. Clinical practice teams attend four highly interactive two-day learning sessions on:

- the components of good chronic disease management;
- how to integrate the components into clinical practice; and
- methods for measuring practice change impact on patient health outcomes.

An "action period" will follow each session giving participants an opportunity to practice what they've learned, assess what changes may be necessary and devise alternative approaches if required.

How Do I Become Involved?
The British Columbia Medical Association will be issuing a call for participation in early November 2003.

General practitioner funding support for Learning Session participation is available through the Full Service Family Practice Incentive Program.

2004 Close-off Dates

January 6, 2004	July 6, 2004
January 21, 2004	July 21, 2004
February 4, 2004	August 4, 2004
February 18, 2004	August 20, 2004
March 4, 2004	September 3, 2004
March 22, 2004	September 21, 2004
April 2, 2004	October 5, 2004
April 21, 2004	October 20, 2004
May 5, 2004	November 4, 2004
May 19, 2004	November 19, 2004
June 4, 2004	December 6, 2004
June 21, 2004	December 20, 2004

Bluebook available on the MSP website

http://www.healthservices.gov.bc.ca/msp/

The 2002/2003 *Medical Services Commission Financial Statement* (Bluebook) can be accessed through the MSP web site at:

http://www.healthservices.gov.bc.ca/msp/.

It is listed under both "Facts and Statistics" and "Publications" on the menu bar. The Statement contains an alphabetical listing of payments made to practitioners, groups, clinics, hospitals and diagnostic facilities for the past fiscal year.

Should you wish to purchase the financial statement from Crown Publications, you can order a copy by telephone 250 386-4636, fax 250 386-0221, mail (521 Fort Street, Victoria, British Columbia V8W 1E7), or web site http://www.crownpub.bc.ca

Checking Patient Information

MSP recognizes that obtaining accurate patient information to submit a claim is sometimes difficult. The following suggestions may be helpful.

Obtain Patient Information prior to a visit

- When your patients call for an appointment ask for their name and PHN exactly as it appears on their CareCard.
- Ask your patients to make sure they bring their CareCard with them to the appointment.
- Ask your patients if they have made changes to their name or coverage since their last visit.

Confirm Patient Information at the time of the visit

Teleplan's Immediate On Line Eligibility function provides coverage information while the patient is at your office. This service allows you to:

- Verify coverage for the current date plus the previous six months.
- Learn if a patient is restricted to one physician.
- Check when your patient had their last eye examination.
- Check if subsidy insured service is paid by MSP or patient.

Confirm Patient Coverage prior to the visit

Teleplan's Batch Eligibility function provides overnight verification of patient eligibility. There is no limit to the number of verification requests and the information is available the next morning. As your requests are processed overnight this allows you to submit your next day's or week's roster of patients.

COVERAGE ENQUIRY

All coverage enquiries are now handled electronically by a toll-free automated service. If you need to speak to a client service representative you can call the Victoria number only.

Victoria: **250 952-2654**

Use the Practitioner Information Line

The Interactive Voice Response (IVR) service provides coverage information any time of the day or night. Through this service you can:

- Check the date of patient's last eye examination.
- Check patient's initials/surname.
- Confirm coverage for date of service.
- Verify responsibility for subsidy insured service.
- Transfer to Info-by-Fax.

Victoria	**250 383-1226**
Vancouver	**604 669-6667**
Toll Free	**1 800 742-6165**

Please note: Requests for patient coverage information require a Personal Health Number (PHN).

Designated Statutory Holidays – Year 2004

January 1, 2004	New Year's Day	Thursday
April 9, 2004	Good Friday	Friday
April 12, 2004	Easter Monday	Monday
May 24, 2004	Victoria Day	Monday
July 1, 2004	Canada Day	Thursday
August 2, 2004	B.C. Day	Monday
September 6, 2004	Labour Day	Monday
October 11, 2004	Thanksgiving Day	Monday
November 11, 2004	Remembrance Day	Thursday
December 27, 2004	in lieu of Christmas Day	Monday
December 28, 2004	in lieu of Boxing Day	Tuesday

AUDIT REPORT

General Practitioner

Following an audit, a physician and the MSC reached a settlement in a dispute about billings. Issues included billing MSP for a person accompanying a patient while not receiving an insured service themselves, billing services not rendered, and the absence of clinical records. The practitioner has agreed to make restitution of $200,000, inclusive of audit costs and interest, and also abide by a pattern of practice billing directive. As part of this directive, the Practitioner agreed to (1) bill MSP only for a person who is seen for a medical condition, and (2) maintain adequate medical records as defined by the *MSC Payment Schedule*. The MSC will monitor the doctor's compliance with the pattern of practice directive.

General Practitioner

An apparent violation of a pattern of practice order arising from a previous audit resulted in a second audit of a practitioner. The second audit identified issues related to:

a. billing office visits (fee item 00100) when the sole purpose of the visit was an injection (fee item 00010);
b. billing office visits where the patient attended for an injection and another condition or conditions where the service and frequency of such services could not be medically justified;
c. the maintenance of adequate clinical records.

The practitioner agreed to repay the Commission $51,607, inclusive of audit costs and interest, and abide by a pattern of practice order requiring compliance with the *MSC Payment Schedule* in all future billings.

General Practitioner

Following an audit, a physician and the MSC reached a settlement in a dispute about billings. Issues identified through the audit were:

a. services in excess of what appeared reasonable given the medical status of the patient;
b. the necessity and frequency of house calls (fee items 00103, 00104) and nursing home visits (fee items 00114 and 00115).

The practitioner has agreed to repay the Commission a total of $25,000 inclusive of the cost of the audit and interest and to abide by an appropriate pattern of practice order in all future billing of this nature.

General Practitioner

As a result of an audit, a practitioner has agreed to repay the Commission a total of $87,500 inclusive of the cost of the audit, hearing costs and interest. Issues resulting from the audit included the billing of fees that did not always meet the complexity level criteria of Level I, II and III Emergency Medicine fee items, and the lack of documentation for complete physical examinations and multiple reassessments. The practitioner has also agreed to abide by an appropriate pattern of practice order.

Psychiatrist

A psychiatrist recently agreed to repay the MSC the amount of $15,000, inclusive of audit costs and interest, when an audit revealed clinical records that sometimes consisted of only the patient's name and the date of the encounter. Under the agreement, the psychiatrist agrees to maintain adequate medical records in accordance with the requirements of the *MSC Payment Schedule*.

General Practitioner

Following an audit, a physician and the MSC reached a settlement in a dispute about billings. The main issue was the provision of services in excess of what was reasonable. The practitioner had inadequate control over the number of patients seen, primarily because there was no appointment system in place. The practitioner has agreed to repay the Commission a total of $112,500 inclusive of the cost of the audit. Moreover, the practitioner has agreed to abide by an appropriate pattern of practice order in which the frequency of service is justified by medical necessity and to keep adequate medical records such that the rationale for treatment can be clearly understood by another practitioner. The Commission will continue to monitor this practitioner's practice to ensure compliance with the order.

General Practitioner

An audit of a general practitioner's practice revealed some inappropriate MSP billings. Of particular concern were complete physical exams (00101) which were not medically necessary or did not otherwise meet the *MSC Payment Schedule* criteria. There were also concerns about counseling visits (00120) which did not involve patients with significant emotional distress or a difficult medical problem. The practitioner has agreed to repay the Commission $32,588 inclusive of audit costs and interest and to abide by an appropriate pattern of practice order in all future billings.

Internal Medicine

Having waived the right to a hearing, a practitioner was ordered to repay the Medical Services Commission $526,388. The repayment was based on findings from an audit that the practitioner had inappropriately billed complete physical examinations (fee item 00101), emergency visits (fee item 00112), allergy tests (fee item 00765), and consultations (fee item 00510). There was also evidence of over-servicing in the management of routine problems (e.g. excessive frequency of follow up visits and home visits). The practitioner subsequently declared bankruptcy. The file was closed in February 2003, upon receipt of a final settlement from the practitioner through the bankruptcy process. The total amount recovered was $193,253.

Clinic (Physician Group)

The Audit and Inspection Committee referred this clinic for audit as a result of concerns about the apparent over-servicing of patients spread across a number of physicians in the practice. The concerns arose as a result of profile reviews undertaken on all of the practitioners working in the clinic. The reviews indicated that the actual costs of general practitioner services for the clinic patients seemed to exceed, by a significant degree, both the age/gender standardized and adjusted clinical group expected costs for that group of patients.

The audit examined the files of the patients who had the majority of their care within the clinic. It was determined that the level of service provided to the patients was appropriate and that the variation from the estimated expected costs could be reasonably explained. While a few billing errors were identified, it was not cost effective to pursue recovery and the file was closed.

Billing Issues Identified by Audit

Referred Out Services

An article in the Summer 2000 edition of the MSP Physicians' Newsletter reminded practitioners that the attending physician should always put his or her own billing number on requisitions for diagnostic tests and x-rays. It has been brought to our attention that some emergency room physicians and specialists making secondary or tertiary referrals are putting the billing number of the patient's primary physician on requisitions for tests or x-rays rather than their own number. The well-meaning intention of this practice is to direct reports to the primary physician, but this results in profile irregularities. To ensure that copies of reports and consultations are forwarded to other physicians, physicians should complete the section provided on the laboratory requisition form for this purpose. Please be aware that the billing number of the physician that actually ordered the tests or x-rays should be used to identify the referring physician on the claim.

Practitioner profiles are only as good as the information we receive from your offices; we depend on your accuracy so that we can provide you with useful and correct reports.

Removal of Warts and Benign Skin Lesions – Billing Policy

Due to ongoing concerns regarding the inappropriate billing for treatment of benign skin lesions and warts, practitioners are reminded that the removal of warts, moles and other benign lesions for patients 16 years or older is not considered an insured service and is not billable to MSP, **unless it is considered medically necessary.** Persons under 16 years of age are excluded from this policy. For further information, please refer to the Preamble to the Payment Schedule, section B16-2-4(4).

Daily Hospital Visits

Where more than one physician sees a patient in hospital, in most cases the only physician who should bill daily hospital visits is the most responsible physician (MRP). For surgical cases, the surgeon is determined to be the MRP during the six-week post-operative period. Other physicians involved in the case should either bill directive care (for specialists), or supportive care (for general practitioners) unless they are providing medical management of a condition unrelated to the surgery (e.g. diabetes).

In non-surgical cases, when both a specialist and a general practitioner bill for daily care, MSP cannot determine who the MRP is. MSP's computerized payment system will pay the physician whose claims are submitted first for daily care, and pay the other physician(s) supportive or directive care. If the MRP has been paid the lesser amount, claims must be re-submitted with a note record indicating that the physician was most responsible for the patient's care. In these cases, adjustments may be done to ensure that payment is appropriate. In the event of a dispute, MSP may require hospital records or other documentation to determine which physician was the MRP.

- In order to avoid disputes, only the most responsible physician should bill daily visits (except as noted below). Physicians other than the MRP should bill directive care (for certified specialists) or supportive care (for general practitioners).

- Daily, supportive and directive care visits are normally calculated from the date of admission not the date the physician first sees the patient in hospital. However, in the case where a specialist is referred for a new complaint within the course of the hospital stay, daily or directive care will be calculated based on the date of the initial consultation.

When the acuity of the patient's illness is such that more than one physician must visit the patient on a daily basis, or when different specialties are seeing the patient for a separate, serious medical condition (e.g. heart disease and spinal fracture), daily care for more than one physician will be given independent consideration. This information must be clearly stated in the note record field.

Daily Volume Limit (HVLIPS)

If you have billed claims for the incorrect date of service, and it results in the daily volume limit discount being applied to your claims, please take the following steps to correct your account:

1. Submit debit request records (submission code 'E') for any **paid** claims that are incorrectly billed for the date of service.

2. Submit debit request records (submission code "E") for any correctly billed claims that have been paid at 50 percent because of the daily volume limit (explanatory codes DR, H5 on debit and HK, H5 on credit).

3. **Do not** submit debit request records for any claims that are **correctly billed and paid** for that date of service.

4. If **any** claims have been cut by 100 percent (explanatory codes DR, H1 on debit), contact MSP to have these claims manually removed from the practitioner's daily volume limit for that date of service. Your office cannot debit claims electronically that have a zero dollar payment.

5. When this has been done, any outstanding claims for the date of service may be rebilled.

Guideline Revision

Detection and Treatment of *Helicobacter pylori* Infection in Adult Patients

Recommendation 4: To diagnose infection

To diagnose *H. pylori* infection, the C13 urea breath test is currently recommended in BC because of its sensitivity. Serology is used where the C13 urea breath test is not available. **Fecal antigen testing can be used where available.**

Urine and saliva antigen testing is no longer recommended.

Gastroscopy for the sole purpose of detecting *H. pylori* is not cost-effective. However, the added cost of a gastric biopsy is minimal if endoscopy is being undertaken for other indications.

Table 1: Tests for the diagnosis of active *Helicobacter pylori* infection

Tests for *H. pylori*	Test detects presence of:	Sensitivity	Specificity
C13 urea breath test – nonradioactive	active infection	high	high
Serology – whole blood or serum	antibody – active or past infection*	high	low
Fecal antigen testing	**active infection**	**high**	**high**
Endoscopic gastric biopsy – pathology	active infection	high	high

*Antibody tests will remain positive for at least 1-2 years following successful eradication.

Added to references:

8. Versalovic J. *Helicobacter pylori*: Pathology and diagnostic strategies. Am J Clin Pathol 2003;199:403-412.

Reviewed: September 2003

For complete *Guideline* please see web site: http://www.healthservices.gov.bc.ca/msp/protoguides/gps/hpylori.pdf

Update to Teleplan's Web Access (Internet)

Teleplan's Web Access has been in production for all Teleplan users since January 2002 and has proven very successful. Currently 1,850 (46%) of sites send claims through Teleplan Web, this represents 67% of the monthly input volume of 6.2 million claims.

On April 11, 2003, we advised all vendors that after June 2003 MSP would no longer issue Teleplan SIMPC software. Teleplan Web is available for use by all Teleplan SIMPC users who have internet capable computers. If you have ADSL, Cable or a private ISP Dialup modem then all you need to do is call your vendor and ask about their migration progress.

We encourage you to migrate as soon as your vendor has provided you with the necessary information to access our site and transmit your data to MSP. Your vendor will either have you use a browser or a special program (API). If you do not have ISP access contact MSP's Teleplan Support Centre at 1 800 663-7206 for access instructions to our SpanDial account connection which allows access to MSP's Teleplan Web only.

Chronic Disease Management

Success Story #2:
When Practice Makes Perfect

In October 2002, 89 family physicians received letters of congratulations from the BC Medical Services Commission for providing optimal care to patients with diabetes. A subsequent survey (http://www.healthservices.gov.bc.ca/cdm/research/diab_physsurv_results.pdf) of these physicians was conducted to learn more about their clinical practice. The following profiles introduce you to two of these physicians, who share their approach to effective diabetes care.

Dr. Michael Paletta

When it comes to providing good diabetes care, Dr. Michael Paletta is one of BC's top performing physicians. If you wanted to sum up the key to his success, it would be having good information and knowing how to apply it for maximum patient benefit.

His emphasis on having a good clinical process can be traced back 13 years ago when, as a locum, he noted that practices providing the best care used clinical guidelines, screened their high-risk patients for diabetes, had patient health summaries, and incorporated preventive interventions.

When he later established his own primary care practice in the lower mainland, he embedded diabetes best practices into his clinical work, and encouraged his patients to participate in good diabetes management.

"As a physician, you want to be sure that what you do will make a difference. At the same time, patients want to be confident that what you're asking them to do is worth the effort," notes Dr Paletta.

Objective, evidence-based guidelines on diabetes care provided this assurance, and Dr. Paletta incorporated best practices into his practice in a variety of ways.

"The vast amount of clinical information out there, and the amount of paper in patient files is overwhelming," he notes. Having had the advantage of developing their own clinical information system, the practice incorporated diabetes care guidelines and patient diabetes flow sheets into the office's computerized management system.

"Computerizing your office doesn't make up for a lack of good clinical process," emphasizes Dr. Paletta. "But it does help you organize and quickly access information." The technology has reminders that prompt follow-up on certain issues or patient call back when they are due for their next test.

As part of educating his patients in managing their diabetes, he discussed the purpose of various diagnostic tests, gave them a schedule of when their next tests were due, and encouraged them to be proactive in their care.

Dr. Paletta stresses that it is critical to empower patients so they feel they can take steps to improve their health and well being. The first step is having evidence-based information on what works, and then communicating this information in terms that people can easily understand.

"To help a patient make changes, I would use the evidence to paint a picture of where they are now, where they will be if their diabetes is not kept under control, and where they can be if they worked with me in managing their diabetes. This often took the form of a graph showing how you can make a big difference from making small changes."

"Something as simple as a 20 minute walk each day makes a huge difference in controlling diabetes and stopping the development of serious complications."

The information on how to control diabetes needs to be applied. "Once they have the information, many patients don't know what to do next... where do they start? The challenge was, how do I get my patients to move from points A to B."

This involved developing a step-by-step process in which Dr. Paletta worked with his patients to develop an action plan that involved setting realistic

goals, following-up with patients to review their progress, and going over the results of diagnostic tests. "Specifically, discussing what the numbers actually meant in terms of keeping their diabetes under control and stopping the onset of serious complications."

"Everything is a planned process," notes Dr. Paletta. "Break things down. First start exercising, and then stop smoking. Change takes time. Setbacks occur, but don't get discouraged."

"One of my roles was to guide my patients through this change process...be their coach and explain what they would get out of what they were doing, why they were taking certain medications...and to be their personal ally giving them a sense of achievement when they reached goals, and helping them when they were struggling."

Dr. Paletta also looked to resources available in the community that could assist his patients in making lifestyle changes. "Receiving quality dietary advice early on is very important in achieving good health outcomes," he adds. "Early after diagnosis, I would refer my patients to the local diabetes clinic for sound, professional advice on healthy eating choices from a registered nutritionist."

Dr. Paletta has many perspectives on the importance of good diabetes care since his medical career has included both fee-for-service family practice and hospital care, where he has witnessed first hand the devastating results of poorly managed diabetes, including the end stages of heart disease, kidney disease, amputations, and other serious complications requiring hospitalization.

"A feeling that something is futile is the greatest obstacle to change. We know, however, that good diabetes care makes a difference and it needs to be optimized at the community level," says Dr. Paletta. He also notes that since diabetes is often first diagnosed when a person is in hospital, hospital-based physicians should also be aware of diabetes standards of care for discharge planning purposes.

Primary care is a leveraging point for improving chronic care management. It offers the best opportunity for screening, prevention, early intervention and effective management. Dr. Paletta's approach to diabetes care is an excellent example of how to provide optimal care to patients.

2. Dr. Nevin Kilpatrick

To say that Dr. Nevin Kilpatrick provides good diabetes care may be a bit of an understatement. After all, the level of diabetes care he has achieved not only makes him one of BC's top performing family physicians, but also ranks among the ten best results achieved in the province.

Dr. Kilpatrick credits his excellent results to his commitment to providing high quality, patient-centred care.

His approach stresses the importance of a well-informed physician, a knowledgeable and activated patient, and a good therapeutic relationship between patient and physician. Dr. Kilpatrick has incorporated best practices into his diabetes care and emphasizes the importance of having objective clinical guidelines based on the best scientific evidence. He notes, "A mountain of health information currently exists, but you have to carefully evaluate it to make sure it is based on scientifically sound medical research." One of his goals is to help patients become experts on their own health, and he finds it counter-productive when they receive diabetes information that reflects certain biases.

Intrinsic to his approach to diabetes management is patient education on the nature of diabetes and its serious health consequences, the importance of diagnostic testing and reviewing what the test results mean with patients, and how medication and lifestyle change can help control diabetes.

Coaching patients on how to make the lifestyle changes that will help them achieve better diabetes control (e.g., increased exercise, weight loss, stopping smoking) is an important part of their care.

Dr. Kilpatrick works with each patient to develop an individualized care plan that sets out realistic goals and introduces lifestyle changes so they become habit – just another part of one's daily activities.

"Not only do you have to be well-informed about the evidence, you also need to be well-informed

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When Practice Makes Perfect ... continued

about your patient. You have to know if he or she is ready to make changes – what kind of changes are they ready to make – how much change at one time is possible. You also have to prioritize what is most important to get under control now, and what can be dealt with later."

He also regularly follows-up with patients and asks about their progress, provides encouragement, and helps set more manageable goals when a patient is struggling.

Dr. Kilpatrick does not rely on clinical information system technology to provide reminders for patient recall when someone is due for their next diagnostic test. Instead, he keeps a note in their chart and provides a reminder during the patient's next office visit. He also gives his patients a timeline of when their next tests are due, and expects them to be proactive in making sure they are up-to-date.

He adds, "The nurses on our health care team are an integral part of the practice and play an important role in diabetes care. They undertake glucose and urine testing, teach patients how to test their blood glucose levels and how to use insulin. They also provide education on foot care, which is a critical aspect of diabetes care."

Dr. Kilpatrick emphasizes that fragmentation of care is the worst thing for a patient. "The family doctor is the portal into the health care system, and continuity of care is very important. In terms of chronic disease management, 'carve-out' models have been shown to be ineffective in reducing the burden of chronic disease."

"The most important thing I can do for my patients, is give them peace of mind," notes Dr. Kilpatrick. Providing evidence-based diabetes care and empowering patients to become experts on their own health is certainly a first-rate way of achieving this goal.

For more information on effective diabetes care, contact: hlth.cdm@gems1.gov.bc.ca

Laboratories to report eGFR

As of October 2003, many laboratories in British Columbia are reporting the estimated glomerular filtration rate (eGFR) for the majority of serum creatinine tests ordered for adult out-patients.

The eGFR is a mathematical estimate of the true glomerular filtration rate, widely accepted as the best overall measure of kidney function, and is based on the patient's serum creatinine, age and sex. The utility of the eGFR has been established in large clinical trials,[1] which have determined that the eGFR is highly correlated with a "gold-standard" glomerular filtration rate as measured by radio-isotope methods.

There are at least three major advantages to reporting the eGFR rather than serum creatinine measurements alone:

1. While serum creatinine measurements have long been used as an indicator of kidney function, there are many problems with creatinine assays. In particular, creatinine levels often do not rise above the upper reference limit until there has been a significant decline in the patient's glomerular filtration rate. By mathematically "adjusting" serum creatinine measurements for patient age and sex, the eGFR overcomes this problem and is therefore much more sensitive at detecting early kidney disease.

2. Creatinine clearance measurements, based on serum creatinine and 24-hour urine collections, do not correlate with "true" glomerular filtration rates as well as the eGFR does. This is most likely due to difficulties in obtaining accurate 24-hour urine collections. Consequently, there should be little or no need for 24-hour creatinine clearance measurements once the eGFR is reported.

3. Interpretation of results is easier. All patients will have the same reference interval (≥ 60 ml/min/1.73m2). Staging of kidney disease, based on eGFR, is possible. A patient with a healthy kidney function will have an eGFR of about 100 ml/mir/1.73m2 and patients with impaired kidney function will have eGFR's that appear to be a percentage of "normal".

Note that the analytical methods used for measuring serum creatinine vary between laboratories so that the level of serum creatinine reported may depend on the laboratory that performed the test. This will affect the eGFR. A program will therefore be introduced to standardize the measurement of creatinine province-wide so as to remove this variation.

Chronic kidney disease is defined as either kidney damage or GFR < 60 mL/min/1.73 m^2 for a period of at least 3 months. (Kidney damage is recognized by pathologic abnormalities or markers of damage, including abnormalities in blood or urine tests or imaging studies.) All patients meeting these criteria should have the cause determined and the rate of GFR decline assessed. This can often be managed by the primary care physician through clinical and laboratory investigations.

The incidence of end-stage kidney disease and the number of patients requiring dialysis is increasing at the rate of 8-10 % per year. High-risk groups include those with diabetes, hypertension and cardiovascular disease. Identification of patients with small declines of glomerular filtration rate will permit intervention at an early stage of kidney disease when the disease process can be slowed or reversed. These issues will be addressed in a forthcoming guideline, *Identification, Evaluation and Management of Patients with Chronic Kidney Disease*.

1. Levey AS et al. A more accurate method to estimate glomerular filtration rate from serum creatinine: a new prediction equation. Modification of Diet in Renal Disease Study Group. Ann Intern Med 1999;130(6):461-70

Intravenous Infusion of Local Anaesthetic for Chronic Pain Management

MSP receives claims for a variety of fee items for intravenous infusion of local anaesthetic (e.g. IV Lidocaine) for chronic pain management. The only correct fee item for this service is 01159 - IV injection for diagnosis and/or therapeutic management of pain syndromes – local anaesthetic only.

PharmaCare Special Authority (SA) Form

In accordance with the decision of the Medical Services Commission (MSC) on March 12, 2003, the completion of the PharmaCare Special Authority (SA) Form is part of the regular office visit and as a consequence, no charge will be made for its completion.

New Explanatory Codes

F9	Payment/refusal of the original claim cannot be reviewed until receipt of a rebilling plus additional details and/or operative/pathology report, if applicable.
LQ	Visit fees are not payable at the time surgical anaesthetic services are rendered.
MK	Fee item 13005 is not payable when the patient is a registered bed patient in an acute care hospital.
ML	Fee item 13005 may only be billed once per day per physician per patient.
MN	Fee item 13005 is not payable in addition to services provided on the same day/same physician/same patient.

MSC Payment Schedule on the MSP Web Site

The updated *MSC Payment Schedule* is available on the following web site:

http://www.healthservices.gov.bc.ca/msp/infoprac/physbilling/index.html

The on-line version of the *Payment Schedule* is updated on a regular basis. Changes are made directly to the schedule. No separate updates are posted.

Diagnostic Facility Assignment Form

To avoid delays in processing, please ensure that you include your facility number in the appropriate field on the form. A copy of the revised form is included in this newsletter. It is also available through Info by Fax at 250 356-9605. All earlier versions of the Assignment Form should be destroyed.

Please note: the wording on the reverse side of the Diagnostic Facility Assignment form has been amended.

The Full Service Family Practice Incentive Program

A Joint Initiative Of

**The BC Ministry of Health Services,
British Columbia Medical Association &
Society of General Practitioners Of BC**

Providing full-service family practice is a challenge for many of BC's general practitioners. In response to the concerns expressed by BC general practitioners, the BC Ministries of Health Services and Planning, the British Columbia Medical Association, and the Society of General Practitioners of BC have developed the Full Service Family Practice Incentive Program.

This 2-year initiative is funded through a $20 million allocation set aside for general practice services under the Subsidiary Agreement for General Practitioners, November 2002. It offers BC general practitioners the opportunity to participate in any of the following three financial incentive programs to enhance patient access to comprehensive health care:

1. **General Practitioner Obstetrical Care Incentive**

   In order to encourage and support low-moderate volume delivery practice, general practitioners currently performing a single delivery per day will be eligible to receive a 50% bonus on the MSC Payment Schedule delivery fee codes 14104 or 14109, for up to a maximum of 25 deliveries per calendar year.

2. **Structured Collaborative Participation Funding**

   This funding will support general practitioner participation in General Practice Services Committee sanctioned structured quality improvement collaboratives for chronic disease management.

3. **Chronic Care Practice Enhancement Incentive**

   The pilot program supports comprehensive, evidence-based management of congestive heart failure and diabetes mellitus. General practitioners are eligible to receive an annual payment of $75 for each patient with a confirmed diagnosis of diabetes mellitus or congestive heart failure whose clinical management is consistent with BC clinical guidelines recommendations.

The Full Service Family Practice Incentive Program represents a new approach for ensuring better patient care through full service family practice. It will be evaluated to determine its impact on quality of care and patient health outcomes.

Information on how to participate in any of the three incentives is available on the Ministry of Health Service's CDM website, http://www.healthservices.gov.bc.ca/cdm/practitioners/fullservice.html

Contact
phone 250 952-3124 or
email: hlth.cdm@gems1.gov.bc.ca.

Fees Funded by the Full Service Family Practice Fund

The following listings and payment rates are not fees included in the usual payment schedule but are listings administered through the Claims payment system and funded from the Full Service Family Practice Fund.

To facilitate claims processing of these and other listings that are not funded from the physicians' fee-for-service budget, the following prefix is added under Preamble B.14:

G - designates listings which are administered through the Claims payment system but are not funded through the physicians' Available Amount.

This prefix is hereby added to the following listings:

G14000 Incentive for Full Service General Practitioner – obstetric delivery bonus

Notes:

i) Payable to family physician performing only a single delivery on any one day, at 50% of primary delivery listing (14104, 14109),

ii) Physician must also be responsible (or share responsibility) for providing patient's general family practice medical care,

iii) Payable only when fee item 14104 or 14109 billed in conjunction,

iv) Maximum of one bonus per patient delivered, up to a maximum of 25 bonuses per physician per calendar year.

G13050 Incentive for Full Service General Practitioner – annual chronic care incentive bonus $75.00

Notes:

i) Applicable only for patients with confirmed diagnosis of diabetes mellitus or congestive heart failure,

ii) Claim must include relevant ICD-9 code (diabetes – 250;congestive heart failure – 4280),

iii) No more than one incentive payment per patient in a consecutive 12 month period for each disease,

iv) BC Patient Flow sheet must be completed and care must be consistent with BC Clinical Guideline recommendations for diabetes mellitus and congestive heart failure,

v) Not applicable to direct patient care that is considered part of the management of patients with chronic conditions,

vi) Physician must also be responsible for managing the patient's diabetes mellitus and/or congestive heart failure and have been responsible for providing the patient's longitudinal general/family medical care.

List of Inserts

1. Assignment of MSP Payments for Diagnostic Facility Services – Notice to Practitioners and Payees
2. Update to the Medical Services Commission *Payment Schedule*
3. Letter to Physicians re: Daily Dispensing
4. Congestive Heart Failure Collaborative – Highlights
5. MSP Bulletin
6. MSCommuniqué Vol 3 #3
7. VIHA Diabetes Patient Survey

Update from the BC Guidelines and Protocols Advisory Committee

The Guidelines and Protocols Advisory Committee (GPAC) was established under Section 5(1)(o) of the *Medicare Protection Act* as an advisory committee to the Medical Services Commission (MSC). Joint responsibility for developing guidelines for medical services lies with the BCMA and Ministry of Health Services.

GPAC intends its guidelines to provide practical and easy-to-follow advice to general practitioners for effective patient care. The guidelines are based on scientific evidence, and are modified for circumstances in B.C.

Current published guidelines are listed below. The Committee has recently turned its focus toward the development of guidelines for the diagnosis and management of chronic diseases with the aim of improving overall care of patients with one or multiple chronic illnesses. Chronic disease management guidelines are marked with CDM to identify them as such.

All guidelines and protocols are available on the Medical Services Plan (MSP) web site at: http://www.healthservices.gov.bc.ca/msp/protoguides/

Printed copies are also available from the Ministry of Health Services Utilization Management Branch. Call 250 952-1347 or contact the program at: hlth.guidelines@gems6.gov.bc.ca

Published Guidelines

- Acute Ankle Injury, X-ray for
- Ambulatory ECG Monitoring (Holter Monitor and Patient-Activated Event Recorder)
- Antiepileptic Drug Concentration Measurement in Adults
- Antinuclear Antibody (ANA) Testing for Connective Tissue Disease
- Asthma, Diagnosis and Management of CDM
- Bone Density Measurement
- Cataract in Adults, Treatment of
- Chest Pain
- Chest X-rays in Asymptomatic Adults
- Cholesterol Testing, Adults Under 69 Years
- Curative Resection of Colorectal Cancer, Follow up of Patients
- Diabetes Care CDM
- Diarrhea - Suspected Infectious, Investigation of
- Drugs of Abuse in Urine: Methadone Maintenance Program, Detection of
- Dyspepsia, Clinical Approach to Adult Patients with
- Electrocardiograms
- Erythrocyte Sedimentation Rate
- Gallstones in Adults, Treatment of
- Gastroesophageal Reflux Disease, Clinical Approach to Adult Patients with
- Genital Specimens, Office and Laboratory Management of
- Glucose and HbA_{1c} Tests in Diagnosis and Monitoring of Diabetes Mellitus, Use of
- Heart Failure Care CDM
- Helicobacter pylori Infection in Adults, Detection and Treatment of
- Hepatitis B – Chronic, Clinical Management of CDM
- Hepatitis C – Chronic, Clinical Management of CDM

- Homocysteine Measurement in the Evaluation of Atherothrombotic Disease, Use of
- House Calls
- Hypertension - Essential, Part II: Treatment of CDM
- Hypertension, Part I: Detection and Diagnosis CDM
- Iron Deficiency, Investigation & Management of
- Iron Overload, Investigation and Management of
- Macroscopic and Microscopic Urinalysis and Investigation of Urinary Tract Infection
- Mammography, Use of Diagnostic Facilities for
- Metastatic Bone Disease in Newly Diagnosed Prostate Cancer Using Nuclear Medicine Techniques, Investigation of
- Osteomyelitis – Suspected, in Normal Bone Using Nuclear Medicine Techniques, Detection of
- Otitis Media with Effusion (OME)
- Otitis Media, Acute (AOM)
- Ova and Parasite Testing of Stool Samples
- Prenatal Cytogenetic Testing
- Prenatal Ultrasound
- Pre-Operative Testing
- Serum Ferritin and Total Iron and Iron Binding Capacity, Use of
- Sleep Apnea - Obstructive, Assessment and Management of
- Sleep Complaints in Adults, Primary Care Management of
- Sore Throat, Diagnosis and Management of
- Thyroid Function Tests in the Diagnosis and Monitoring of Patients with Thyroid Disease, Use of
- Viral Hepatitis Testing
- Vitamin B_{12} and Folate Deficiency, Investigation and Management of CDM

Updated List of Province and Territory Codes and Registration Numbers

Province or Territory	Code	Registration Number	Province or Territory	Code	Registration Number
Alberta *	AB	9 digits	Nunavut	NU	9 digits
Manitoba **	MB	6 digits	Ontario ***	ON	10 digits
Newfoundland	NF	12 digits	Prince Edward Island	PE	8 digits
New Brunswick	NB	9 digits	Saskatchewan	SK	9 digits
Northwest Territories	NT	7 digits	Yukon	YT	9 digits
Nova Scotia	NS	10 digits			

* Alberta provides each family member with a unique lifetime personal health number.

** Manitoba provides one registration number for the family – use the 6 digit number when billing for each family member.

*** Ontario will not provide BC physicians with the registration numbers of Ontario Health patients that are being treated in BC. MSP has assisted with finding registration numbers in the past but in the future you will need to bill the patient directly or bill Ontario Health.

Please note: Routine Pelvic Examination (fee item 14560) including papanicolaou (no charge when done as a pre and post-natal service) is not a benefit on a reciprocal basis for patients from another province unless there is a medical requirement. This is in accordance with Preamble A.4 of the *MSC Payment Schedule*, which states "routine periodic health examinations" are excluded under the Reciprocal Agreement. If the service is performed for a medical reason other than screening, please include that information in a note record with your claim.

Proton Pump Inhibitors (PPIs) - Reminder of PharmaCare Criteria Changes

On July 15, 2003, PharmaCare changed the criteria for Special Authority (SA) coverage of Proton Pump Inhibitors (PPIs). Patients requiring SA coverage—be it initial coverage or renewal of coverage—are now required to try treatment with rabeprazole (Pariet®) before becoming eligible for SA coverage of other PPIs. If a patient experiences treatment failure or intolerance to rabeprazole, the physician can then request an indefinite SA for all other PPIs for that patient. Children, patients receiving short-term "triple therapy" for helicobacter pylori infections or patients with severe complicated conditions who are already stabilized on another PPI, are not required to try rabeprazole.

Patients who had an existing SA in effect on July 15, 2003, were not required to switch to rabeprazole until the original expiry date of their SA or January 14, 2004, whichever came first.

Physicians do not need to submit a request for SA coverage of rabeprazole for these patients because an indefinite SA for the medication has already been entered on the patient's PharmaNet record. However, these patients will require a prescription for rabeprazole before the end date of their current PPI coverage.

Practitioner SA Exemptions

With the introduction of the new coverage criteria for PPIs, changes were made to practitioner SA exemptions for these medications. As of July 15, 2003, exemptions have been maintained for specialist physicians who, by nature of their specialty practice, may experience an administrative burden.

Gastroenterologists and individually identified physicians have SA exemptions for:

- rabeprazole 10 mg (Pariet®) - usual daily dose is 20 mg (2 x 10 mg tablets)
- omeprazole 10 and 20 mg (Losec®)
- pantoprazole 40 mg (Pantoloc®)
- lansoprazole 15 and 30 mg (Prevacid®)

PharmaCare has requested that these physicians conscientiously apply the PharmaCare coverage criteria, employing rabeprazole as the first line treatment for new patients. Prescribing practices will be monitored to assess voluntary compliance.

Physicians performing endoscopies have an SA exemption for:

- rabeprazole 10 mg (Pariet®) - usual daily dose is 20 mg (2 x 10 mg tablets)

Some individual endoscopists have also been granted exemptions for other PPIs on the basis of their patient load.

PharmaCare will consider PPI SA exemptions for individual physicians if a significant administrative burden is evident and the physician:

- specializes in internal medicine, or
- is a rural physician treating the majority of gastroenterology patients in the region.

Requests may be addressed to Lynda Chiu, Pharmacy Consultant, PharmaCare, PO Box 9655 Stn Prov Govt, Victoria BC V8W 9P2.
Please note that practitioner SA exemptions for esomeprazole (Nexium®) are not available.

BRITISH COLUMBIA Ministry of Health Services
Medical Services Plan

ASSIGNMENT OF MSP PAYMENTS FOR DIAGNOSTIC FACILITY SERVICES

NOTICE TO PRACTITIONERS AND PAYEES

IMPORTANT – YOU MUST READ BOTH SIDES OF THIS FORM

I, Dr. _____ , Practitioner Number _____ ,
Name of Physician - "the Assignor"

hereby assign to _____ ,
Name of Diagnostic Facility - "the Assignee"

Payment #(s) _____ , and Facility #(s) _____ ,

all payments owing to me by the Medical Services Commission of British Columbia ("MSP Payments") for the following services (check applicable boxes):

- ☐ Radiology
- ☐ Ultrasound
- ☐ Polysomnography
- ☐ Laboratory Medicine
- ☐ Nuclear Medicine
- ☐ Pulmonary Function
- ☐ EMG
- ☐ ECG
- ☐ EEG
- ☐ Other: _____

This Assignment applies to all claims submitted in the format approved by the Medical Services Commission bearing both my practitioner number, _____ , and the Diagnostic Facility's payment #(s) _____ :

(i) for the period from _____ to _____ ; or
Month/Day/Year *Month/Day/Year*

(ii) for the following specific dates _____ ; or

(iii) for a period no greater than (2) years from _____
Month/Day/Year

unless I notify the Commission in writing to cancel this assignment.

I authorize the Commission to direct the MSP payments to any address specified by the Diagnostic Facility from time to time.

I confirm that I have read and understand the Preamble to the Medical Services Commission Payment Schedule on the reverse side of this assignment. I understand that I must comply with the *Medicare Protection Act*, the *Medical and Health Care Services Regulation* and all requirements of the Medical Services Commission Payment Schedule.

I understand that payment by the Commission to the Diagnostic Facility under this Assignment discharges the Commission of any indebtedness for those same accounts to me, and releases the Commission from any indebtedness to me, my executors, my administrators or other assignees for the amounts paid.

Dated this _____ day of _____ , 20 _____

_____ M.D. _____
Signature of PRACTITIONER *Authorized Signature for PAYEE*

_____ _____
Signature of WITNESS *Signature of WITNESS*

_____ _____
Print Name of Witness *Print Name of Witness*

IMPORTANT NOTICE TO PRACTITIONERS AND PAYEES

Preamble 3, Medical Services Commission Payment Schedule –

An "Assignment of Payment" is a legal agreement by which an attending physician assigns payment for the services specified in the Assignment to another party. The designated party may use the attending physician's practitioner number in combination with its own payment number when submitting claims to the Medical Services Plan (MSP). To authorize the MSP to pay a designated party, the attending physician must complete and file an "Assignment of Payment" form. However, even though the payment has been assigned, the responsibility for the delivery of clinical services, and its appropriate billings remains with the physician whose practitioner number is used.

To the extent the information submitted to MSP is subsequently found to be untrue and/or the billings inappropriate, depending on the circumstances, the physician and/or the diagnostic facility will be liable to repay both the technical and professional components of the claims. Claims will be recovered pursuant to section 30 or section 37 of the *Medicare Protection Act*.

To limit liability –

- In the case of physicians providing limited or locum coverage the time period indicated on the form must be the same as the time period assigned for the limited or locum coverage.
- Physicians who have made a two (2) year assignment of payment to a diagnostic facility must advise MSP in writing if he or she ceases to be associated with the diagnostic facility before the assignment expires.

Provider Programs
Claims Division
Box 9480
Victoria, BC V8W 9P6
Telephone: 250 952-2654
Fax: 250 952-3101

BRITISH COLUMBIA Ministry of Health Services

Update to the Medical Services Commission Payment Schedule

Preamble

Addition:

The following wording is hereby added to Preamble B.4. of the Medical Services Commission *Payment Schedule* as indicated:

B.4.g. House Calls

i) A house call is considered necessary and may be billed only when the patient cannot practically attend a physician and the patient's complaint indicates a serious or potentially serious medical problem that requires a physician's attendance in order to determine appropriate management;

ii) If a house call is determined to be necessary and is initiated by the patient during the practitioner's regular office hours, the house call should be billed as a home visit irrespective of when the service was rendered. Service charges do not apply to pre-booked house calls rendered after regular office hours (use 00103);

iii) If a necessary house call is initiated and rendered out of the practitioner's regular office hours, the visit may be billed as an out-of-office visit with the applicable call-out charge (01200, 01201, 01202). Call-out charges apply when the requirements for out-of-office hour premiums are met;

iv) A house call provided for patient convenience should be billed as an out-of-office visit (12200, 13200, 16200, 17200 or 18200) without a service charge;

v) The above also applies to house calls rendered by physicians taking call for other physicians;

vi) As practicality dictates, the necessity and detail and time of the call should be documented in the patient's clinical record.

Diagnostic Procedures

New Fee Items

Effective June 1, 2003 the cancellation dates of the following provisional items have been extended. This Minute will expire on May 31, 2004 or when replaced by a Subsequent Minute, whichever occurs first:

P00921	Varicocele and/or uterine artery embolization – unilateral	$360.90
P00925	Varicocele and/or uterine artery embolization – bilateral	$501.79

Notes:

i) Fee items P00921 and P00925 include all the arteriographies necessary to perform the procedure.

ii) Fee item 08617 or 08618 payable in addition when service rendered in out-patient department.

Amendment

Effective immediately the provisional status (P) of the following items has been deleted and these items are now assigned a permanent status:

Overnight home oximetry (continuous recording of oxygen and pulse)

00910	- professional fee	$27.36
00911	- technical fee	$15.32

Note:
Fee items 00910 and 00911 are limited to Category III pulmonary function laboratories and/or polysomnography laboratories with the established personnel qualifications for such laboratories.

Ophthalmology

Effective immediately, the descriptions of the following items are amended as indicated:

02067	Manual retinal nerve fibre layer photography and neuro-retinal rim assessment
02068	- professional fee
02069	- technical fee

Notes:

i) **Fee item 02067 – 02069 include examination of both eyes whether at one time or two separate visits.**

ii) **Recommended frequency depends on the patient's clinical circumstances but cannot be billed at intervals less than 180 days without written justification.**

New fee item

The following item has been approved on a provisional basis, effective immediately. This Minute will expire June 30, 2004 or when replaced by a subsequent Minute, whichever occurs first:

P22067	Computerized retinal nerve fibre layer photography and neuro-retinal rim assessment (e.g. Heidelberg, GDX)	$63.92

Notes:

i) **Requires both qualitative and quantitative assessments.**

ii) **Includes examination of both eyes whether at one time or two separate visits.**

iii) **Recommended frequency depends on the patient's clinical circumstances but cannot be billed at intervals less than 180 days without written justification.**

Fee item amendment

Effective immediately, the description of the following fee item is amended as indicated:

22399	Ophthalmic A-scan for determination of axial length (to be billed only if patient proceeds to eye surgery/procedure as indicated below):

Notes:

i) Eligible indications for billing 22399 include:
   a. Intraocular lens (IOL) implant surgery following cataract removal
   b. Any procedure where a peribulbar or retrobulbar injection is needed and risk of eyeball perforation by the injection needle is a potential danger such as:
      i.) Any ocular surgery requiring local anaesthetic with peri or retro-bulbar block
      e.g. Ptyregium surgery
      Corneal transplant
      Retinal surgery
      ii.) Retrobulbar injection of therapeutic agents
   c. Axial or pathological myopia-serial assessments
   d. Diagnosis of conditions where axial myopia is a diagnostic criteria (e.g. Marfan's)
   e. Posterior staphyloma-serial assessments
   f. Pre-operative assessment for radioactive plaque implant-Brachytherapy for ocular melanoma

ii) Provide indication in note record when non-IOL implant indicated A-scan is performed

iii) Claims for IOL implant patients should indicate either:
   - R/L for cataract surgery – on wait list or
   - R/L eye for cataract surgery (with the surgery date indicated).

iv) Limited to once per year, per eye. A note record indicating the need for additional scan is required.

Internal Medicine

Amendment

Effective immediately the provisional status (P) of the following items has been deleted and these items are now assigned a permanent status:

Overnight home oximetry (continuous recording of oxygen and pulse)		
00910	- professional fee	$27.36
00911	- technical fee	$15.32

Note:
Fee items 00910 and 00911 are limited to Category III pulmonary function laboratories and/or polysomnography laboratories with the established personnel qualifications for such laboratories.

Obstetrics and Gynaecology

Amendment

The description of the following listing is modified as indicated, effective December 15, 2002:

T04114 Therapeutic abortion by D&E, 18 weeks and over (operation only) $215.45
Anaes. Level 3

Plastic Surgery

New Fee Items:

The following items are effective on a temporary basis from November 1, 2003 until April 30, 2006.

T06228 Arthroplasty of metacarpophalangeal or interphalangeal (hand) joint $247.13
Anaes.Level 2

T06229 Arthrodesis of metacarpophalangeal or interphalangeal (hand) joint $228.28
Anaes.Level 2

Deletion:

The following listing is deleted, effective October 1, 2003:

06230 Capsulotomy, arthroplasty, and arthrodesis $147.43
Anaes.Level 2

The following item is effective on a temporary basis from November 1, 2003 until April 30, 2006.

T06238 Repair of complicated fingertip injury under digital block or anaesthetic (regional/general) $196.76
Anaes.Level 2

Note:
Requires nail bed repair (included removal of nail plate, suturing of nail bed laceration and replacement of nail plate) including associated management of distal phalangeal fracture.

Amendment

Effective immediately, the following note is added subsequent to the indicated fee item:

06231 Reconstruction of rheumatoid hand joints, multiple, e.g. synovectomy, intrinsic release, positioning of extensor tendons, each hand, fee for service, at any one operative session – up to $752.77

***Note*: Only applicable when performed on more than 2 joints.**

Vascular Surgery

Amendment

The following note is added to the following item, which continues to be approved on a provisional basis. This Minute will expire December 31, 2003 or when replaced by a subsequent Minute, whichever occurs first:

P77177	Abdominal aortic aneurysm repair using endovascular stent graft – vascular surgery component	$1,056.08	Anaes.Level 9

Note:
In order to bill P77177, vascular surgeon must be present throughout entire procedure.

Laboratory Medicine

These laboratory fee items are being included with this update as they were approved prior to the BC Laboratories Services Review.

Amendment

Effective July 1, 2003 the cancellation date of the following provisional fees have been extended. This Minute will expire on March 31, 2004 or when replaced by a subsequent Minute, whichever occurs first:

Drugs of Abuse Testing – Screening Assays		
P92510	Methadone Metabolite	$4.33
P92513	Methadone	$4.33
Drugs of Abuse – Confirmatory and Specific Quantitative Assay Testing		
P92513*	Blood Methadone	$56.73

Nuclear Medicine Procedures

Amendment

Effective September 1, 2003, the description of the following fee item is hereby amended as indicated:

P09826	Tumour imaging with metabolic or biological imaging agent (excluding Thallium-201 or Gallium-67) *Note:* Included imaging of the entire torso with tomographic and planar images as indicated.	

New Fee Item

The following item has been approved on a provisional basis, effective September 1, 2003. This will expire December 31, 2003 or when replaced by a subsequent Minute, whichever occurs first:

P95053	Thallium body imaging *Notes:* i. Not payable with 09806, 09817, 09854 or 09826 ii. 09877 payable in addition if the patient brought back for additional imaging the same or next day.	$374.11

BRITISH COLUMBIA

November 2003 450053A

Dear Physician:

It has come to my attention that the number of physician authorizations for "daily dispensing" of medications is increasing.

I understand that daily dispensing can be in the best interest of a patient's health. This practice has had good success in increasing the compliance of frail elderly patients and mental health patients, and is of great practical use in long-term care facilities.

However, the financial cost to our publicly funded PharmaCare program becomes exponential with increased use of daily dispensing. The cost of dispensing one drug for one person for 90 day's supply becomes $774 for daily dispensing instead of $8.60 for a single prescription.

There are some drugs which, and some clients who, require prescriptions for daily dispensing as a medical necessity. However, it is difficult to justify the cost to the British Columbia healthcare system of daily dispensing of, for instance, long-term medications. There is also potential for increased costs being passed along to the patients in instances where pharmacies charge dispensing fees above the current maximum accepted fee of $8.60 per prescription.

I am aware of the issues of patient compliance with dosage instructions, and at the same time aware of the need to maintain dispensing costs at a sustainable level. I respect the responsibility of physicians in making clinical decisions, and the need to identify clinical and management criteria that support each patient's best care and health outcomes. The role of community pharmacists is also critical to the issue of daily dispensing of medications.

.../2

Ministry of Health Services

PharmaCare
Office of the Executive Director

2-2, 1515 Blanshard Street
Victoria BC V8W 3C8
Telephone: 250-952-1706
Facsimile: 250 952-1391

For this reason, I am seeking your input on this issue. PharmaCare is developing a policy statement, which addresses the issue of daily dispensing. I invite your comments by December 31, 2003. Please direct your feedback to:

E-mail: hlth.pcaretrends@gems9.gov.bc.ca
Telephone: 250 952-2642
Fax: 250 952-2790
Mail: Policy Analyst
PharmaCare Policy & Program Analysis
Ministry of Health Services
2-1, 1515 Blanshard Street
Victoria, BC V8W 3C8

I look forward to hearing from you.

Sincerely,

Phyllis Chuly
A/Executive Director
PharmaCare

p.c. British Columbia College of Pharmacists
College of Physicians and Surgeons of British Columbia

CONGESTIVE HEART FAILURE COLLABORATIVE

Highlights

Province-Wide Learning Session One
May 26-27, 2003

healthyheart

"This is not a conference, workshop or symposium where not much happens after it's over. This is a springboard for change. We are building the infrastructure for effective chronic disease management in BC"

— Patrick O'Reilly,
CEO, Healthy Heart Society &
C0-Director, CHF Collaborative

Congestive heart failure has significant human costs – it is a leading cause of death, hospital admission and re-admission among British Columbians 65 years and older. At the November 1st 2002 Congestive Heart Failure Leadership Collaborative, front-line health care professionals clearly voiced the need for changes in how the province's health system is currently organized in order to better support good congestive heart failure management.

BC's health care system was well designed for acute and episodic care, but not for effective chronic disease management.

As one step towards system re-design, the Healthy Heart Society, in collaboration with representatives from various sectors of the province's health system, organized and launched BC's first ever Province-Wide Congestive Heart Failure (CHF) Collaborative. This is a 15-month quality improvement initiative designed to assist family physicians to change their clinical practice for better patient CHF outcomes, and improved professional satisfaction.

This quality improvement technique was chosen because it has consistently been shown to result in clinical office/practice re-design that improves pro-active patient management, care planning, office efficiency, team development, clinical information management, and enhanced physician-patient interaction for improved chronic care management.

Moreover, knowledge of how to change practice for one disease builds clinician understanding and practice re-design for improved management of other chronic diseases as well.

At a system level, this collaborative is setting down the infrastructure for improved practice and patient outcomes for other chronic disease such as diabetes, chronic kidney disease, etc. "Why are we starting with congestive heart failure? Because we have to start somewhere in changing the system for improved chronic care", said Patrick O'Reilly. "The Healthy Heart Society was in the right place at the right time to start this process."

Dr. Chris Rauscher summed up what the CHF collaborative is all about – "Improvement."

As part of his overview of the design of the CHF collaborative, Dr. Rauscher emphasized that a substantial evidence base on how to effectively manage chronic illness now exists - the challenge facing practitioners is how to embed best practices into their workflow.

"There is a performance gap in this province. It's no one's fault per se – the entire health system is not properly organized to support effective chronic care. We can't solve today's problems using yesterday's solutions….

— Dr. Chris Rauscher, Co-Chair
CHF Collaborative Steering Committee

The Institute for Health Improvement's "Model for Improvement" (also known as Plan–Do–Study–Act or Rapid Cycle Change) has been adapted for use by the BC collaborative because it has consistently been shown to successfully assist clinical teams accelerate practice change such that measurable improvements are achieved within approximately 12-18 months.

Practice change consists of the following four phases:

Plan: the team develops a plan for how they will change the quality of care delivered

Do: the team implements the change, collects quality of care and patient outcome data

Study: based on the data collected, the team analyses what happened

Act: the team devises next steps based on their analysis of what happened.

"This is not a research study- rather it's about knowing what you are trying to accomplish, making the changes needed for improvement, and testing in order to know if improvement has been achieved", said Dr. Rauscher.

Each year, approximately 85% of all BC health care dollars are spent on chronic care. The human and financial burden of chronic disease is substantial, and expected to increase over the next few years.

Health professionals are working very hard and want best outcomes, but are frustrated because the system does not provide the right supports - sometimes it even works against providing effective chronic care. Today is a turning point in BC. We are setting down the foundation for change….

— the Honorable Sindi Hawkins, BC Minister of Health Planning

In opening the CHF Collaborative, Minister Hawkins noted that reducing the burden of chronic disease is a priority of the Ministries of Health. However, simply investing more money into doing things the same way will not result in more effective chronic disease management. BC's health care system needs to be re-designed to achieve good outcomes.

The Province is therefore working with the health authorities to implement the Expanded Chronic Care Model, and is investing in concrete tools and products that research has shown improves outcomes.

"There is substantial interest and enthusiasm among BC's health professional organizations to support clinical practice re-design for improved chronic care delivery and patient outcomes," noted Minister Hawkins.

"The Ministries of Health have awarded grants for practice re-design resource development, implementation and dissemination of results to build chronic disease management capacity across the province to the following physician organizations":

- Physician Practice Self-Evaluation Program (College of Physicians and Surgeons of BC)
- Improving Chronic Disease Self Management – An Interactive & Integrated Approach for Doctors and their Patients (BC College of Family Physicians)
- Improving Physician Use Of Health Information System Technology (UBC Faculty of Medicine, Division, Continuing Medical Education)
- Diabetes Collaborative (British Columbia Medical Association)

"Empowering practitioners with information and resources is a key to reducing the burden of chronic disease in this province," emphasized Minister Hawkins.

The Chronic Care Model, developed by the Robert Wood Johnson Foundation (Group Health Cooperative), was adapted to guide improved chronic disease management in BC. The purpose of having a common model is that it provides a coordinated approach to the alignment of activities and resources for maximum benefit.

Dr. Rich provided an overview of the following model components: decision support, information systems, patient self-management, delivery system re-design. He also highlighted examples of how model implementation has significantly reduced the burden of chronic disease in the United States.

The Chronic Care Model has been implemented widely in the U.S…it genuinely works…

—Dr. Michael Rich, Director, Cardiac Rapid Evaluation Unit, Barnes-Jewish Hospital & Assoc. Professor of Medicine, Washington Univ.

Dr. Rich emphasized that all the components of the model must be implemented in order to achieve optimal patient outcomes.

The foundation of good chronic disease management is information that helps the practitioner to:

- identify patients in the practice who have a chronic disease (patient register);
- keep track of patient care and outcomes (patient flow sheets)
- produce individual care plans and issue patient reminders/recall

"Research indicates that providers consistently underestimate ...by as much as 50%...the number of patients with a chronic disease in their practice", noted Mike Hindmarsh. This alone results in many patients not receiving appropriate chronic care.

If a productive patient-clinician interaction is the heart of a good visit, then information is the lifeblood flowing through that interaction...

— Mike Hindmarsh,
McColl Institute for Healthcare Innovation

The presentation dispelled the myth that developing a patient register requires that the medical office be equipped with electronic medical record information technology. If you have it - great. If you don't the following strategies have been shown to be just as effective: a shoebox of 3X5 index cards, a paper log or spreadsheet, a simple database, or a web-based repository.

The patient register does not contain information on all aspects of the patient's medical history – instead, it provides the list of all the patients in the practice with a chronic illness, and summary encounter information highlighting the care provided, the care required at their next visit according to evidence-based clinical guidelines, and health outcome tracking information.

The CHF patient flow sheet included in the BC Guideline for Congestive Heart Failure was cited as a good encounter summary record that could greatly help clinicians identify what needs to be monitored, and therefore, would be particularly helpful for planning visits, issuing call-back reminders, and in planning and monitoring patient self-management.

"Jump in right away and get this information system in place", advised Mike Hindmarsh. "Place colour coded stickers on your patient files to identify who has a chronic disease; then refer to their flow sheet to plan what you want to get out of the next office visit. You'll feel better prepared for the visit, and it will be more productive for both you and your patient".

To assist in patient register development, BC physicians can obtain a list of their CHF (and diabetes) patients through the Ministry's secure website repository. The patient list was developed using Ministry administrative data. The website also contains information on the extent to which the care provided is consistent with BC clinical guidelines. The web site is at: http://www.healthservice.gov.bc.ca/cdm

CHF patient flow sheets will be available for down-loading from the CDM website as well.

"Implementing this decision support into your practice may involved some extra work upfront, but you'll find that it will save you time in the long run and improve patient outcomes," assured Mike Hindmarsh.

Dr. Turgeon is one of five family physicians practicing at the MidMain Clinic in Vancouver. The physicians were frustrated with patient charts, noting that they spent a lot of time "wandering around the chart looking for information". To remedy the situation they implemented CDM decision support into their clinical practice, using the 'shoebox approach' to patient register development.

The other physicians in our practice have asked when other patient registers will be ready, because it makes work so much better...

— Dr. Sue Turgeon, MidMain Medical Clinic

The clinic identified its diabetes population, and developed encounter summaries to help plan care and conduct proper follow-up. A green sticker on the patient chart reminds physicians that the patient has a chronic disease, and they should thus refer to the encounter summary to guide what they need to accomplish during the office visit.

This decision support process was fully implemented in one month, and at minimal cost, noted Dr. Turgeon. Her advice to others is, "Keep it simple. Don't strive for perfection. Pick something to do, and get on with it. You can tweak it later".

Dr. Macgregor noted that system re-design for optimal chronic disease management is an opportunity for physicians to start thinking differently about what happens during the office visit.

"You'd be amazed at the number of chronic care patients you actually have", he commented, "and effective chronic disease management requires a different image in your head -- a shift away from the traditional symptom-driven patient visit, to planned visits".

Dr. MacGregor stressed the importance of having clinical guidelines at the point of clinical care, and shared his experience of finding patient encounter summary information to be critical to maximizing benefit.

He noted, "The summary information not only helps you focus on what you need to accomplish during your next patient office visit, but also assists in targeting opportunistic care and preventing the onset of complications and co-morbidity. The CHF flow sheet is great for summarizing information."

I used to be addicted to the charm of the episodic visit". Effective chronic disease management requires a planned visit approach. It's not as charming, but is far more productive….

— Dr. Art Macgregor, Medical Lead, Southern Vancouver Island HTF CDM Project

He also stresses that patient self-management is essential to reducing the burden of chronic disease. Helping your patient develop goals (weight loss, smoking cessation, increased exercise) and an action plan on how to reach those goals, and monitoring their progress is intrinsic to the planned office visit.

"We need to get away from the mindset that patients will do what we tell them to do-and if they don't, they're non-compliant". In reality, patients do what interests them. The family doctor's office is the logical place for determining what the patient thinks they can do, what they want to do, and what they think they and their doctor can accomplish together.

His advice to the collaborative participants, "Restrain perfectionism! Just get started! Use the data from the CDM secure website to develop your baseline and kick start your planned care -- and then refine and adjust your process as you go along."

Dr. Korndor provided an overview of the burden of CHF, the evolution of the understanding of CHF pathophysiology, diagnosis, symptoms, and classification of severity.

Survey results presented indicate that very few CHF patients understand what CHF is, and what their medications actually do. Alarmingly, in terms of patient self-management, less than 2 in 10 patients know that they should restrict their sodium intake, weigh themselves regularly, or know the warning signs of volume overload.

We should not be surprised to see CHF patients in the ER. Patients appear to know very little about their disease and how to manage it…

— Dr. Jan Kornder, Cardiologist, Surrey Memorial Hospital & CHF Clinic Physician

Dr. Kordner also discussed B-type Natriuretic Peptide (BNP) testing as a new and exciting method for screening asymptomatic CHF, monitoring disease progression and post diagnosis management.

"BNP testing is a powerful tool that can be used at the point of care. It can be done anywhere you can draw blood. This test is very good at quickly differentiating people who are short of breath because of CHF as opposed to COPD". Moreover, it can very accurately classify a patient in the NYHA stages of CHF. This test is not widely available, but it was noted that the CHF collaborative might be a pilot opportunity.

Dr. Ignaszewski's presentation was entitled, *Success with Failure in BC in 2003*, reflecting the fact that "CHF is common, deadly, costly, preventable, and while effective treatment strategies exists – they are greatly under-utilized."

Medical research has identified the etiology of CHF to be neurohormonal, and randomized clinical trials have definitively shown that treatment with ACE inhibitors and beta-blockers can significantly increase patient survival and reduce patient hospitalization – this evidence is the basis for the treatment algorithm found in BC's evidence-based CHF clinical guideline.

Neurohormonal Inhibiting Drug Therapy is a proven effective treatment for heart failure. Yet very few BC patients are receiving this treatment….

Dr. Andy Ignaszewski, Medical Director, St. Paul's Hospital Healthy Heart Program & Heart Function Program

However, Dr. Ignaszewski highlighted that statistics clearly show that CHF is not optimally managed in BC. Specifically, a performance gap exists in the use of neurohormonal inhibiting drug therapy for the treatment of heart failure. Across the province, very few patients are receiving ACE inhibitors and beta- blockers as part of their chronic care.

He stressed that application of the drug therapy algorithm recommendations in the BC CHF guideline will result in reduced mortality, hospitalizations, and improve cardiac function and patient quality of life.

The following are two examples of drug therapy recommendations he provided:

As soon as safely possible, and unless contraindicated or not tolerated by a patient, all of the following patients should be treated with ACE inhibitors:

- *patients with symptomatic CHF, NYHA Class II-IV;*
- *asymptomatic patients with LVEF < 35%-40%;*
- *following acute MI for 6 weeks, or indefinitely in those with LVEF < 40% or clinical evidence of CHF.*

Unless contraindicated or not tolerated, all of the following patients should be receiving a beta-blocker:

- *NYHA class II-III HF and LVEF < 40%;*
- *patients with stable class IV HF;*
- *asymptomatic NYHA class I patients with LV systolic function with LVEF < 40% (particularly post-MI).*

Patient self-management is a key component of the Expanded Chronic Care Model—and many patients find they need assistance in getting the information, skills and confidence to effectively manage their health.

Dr. McGowan introduced collaborative participants to the University of Victoria Centre on Aging's Chronic Disease Management Program as a resource to which they can refer patients for training in self-management.

This program is designed for people with chronic illness to learn healthy ways to effectively live with their condition. It helps individuals develop self-efficacy, problem solving, and coping skills in order to deal with the physical and emotional problems caused by their illness, and to maximize the quality of their lives.

An informed and active patient is a critical aspect of successful chronic disease management…

— Dr. Patrick McGowan, University of Victoria Centre on Aging, Chronic Disease Self Management Program

$900,000 from the Health Canada Primary Health Care Transition was recently allocated to the province's health authorities to support the implementation of the program. Over the next 3 years, Chronic Disease Self-Management Program trainers will work in each of the health authorities to deliver patient self-management programs to several thousand patients living with chronic illness.

Dr. Ruth Medak, a consultant with the Oregon Professional Medical Review Organization, and Connie Sixta, a CHF Collaborative coach outlined the activities that lead to effective CHF management in a clinical practice setting. Their presentation was called *The Model for Improvement-Getting Down To Work.*

During this first CHF Collaborative Learning Session, clinical teams participated in interactive learning groups on how to implement planned visits and case management, patient self-management education tools, integrating decision support into clinical practice. Also presented, was how to accelerate improvement through ongoing testing of changes introduced to clinical practice.

"There was a wonderful sense of teamwork and excitement about improving heart failure. I am really optimistic that the collaborative will have a profound impact on the lives of patients with heart failure and on the people who provide their health care…

…I am envious of the close working relationship among health professionals, the provincial government, and the local health authorities. In this environment, everything is possible.

— Dr. Ruth Medak, Collaborative Faculty, Oregon Professional Medical Review Society

Over the next three months, clinical teams will be implementing and testing the changes. This Action Period will be supplemented by conference calls and "listserv" communications among the participating teams and collaborative faculty who can troubleshoot barriers and suggest ways to overcome them.

Feedback from CHF Collaborative Participants

"The team approach builds really practical small scale collaboration that wouldn't be possible otherwise" (nurse)

"The practical ways all the presentations were done, i.e., how to implement the information, and the opportunity to work with a team and having support appealed the most to me" (physician)

"I loved the learning with Drs. Ignaszewski and Macgregor" (clinic coordinator)

"I learned a lot about congestive heart failure today. The information presented today should be offered as CME" (physician)

"The speakers were so knowledgeable about chronic diseases, improvement and collaborative – so great at pulling it all together" (improvement advisor)

"There is a lot that we can do at the primary care level. We can manage patients at the early stages of this disease, and help patient self-manage their health" (physician)

The second Learning Session of the CHF Collaborative will take place October 6-7, 2003.

healthyheart

For more information on the Healthy Heart Society sponsored CHF collaborative, **contact:**
Liza Kallstrom
604-742-1772
lkallstrom@healthyheart.bc.ca

MSP BULLETIN FALL/WINTER 2003

The Medical Services Plan's Bulletin is provided to help physicians identify patients whose MSP benefits have payment restrictions. This Bulletin provides important billing information for physicians only. Thank you for respecting the confidential nature of this information.

The Bulletin is an updated listing of restricted MSP enrollment numbers for clients who have signed a legal *Agreement of Limitation* form which limits MSP payment responsibilities to one primary care physician. If care is provided by other physicians, the charges must be made directly to the clients. MSP will not accept payment responsibility unless special circumstances are clearly stated. An example of this would be medical care that has been provided by an emergency physician in the hospital emergency room.

MSP is concerned about the potential misuse of CareCards and strongly recommends a complete check of CareCard information at all first appointments. If you suspect any unusual use of a CareCard, please request a second piece of picture identification in order to verify that the CareCard is being presented by the person named on the card.

PHN	Birthdate (MM/YY)	Sex M/F	Physician Number
9013676868	12/54	M	06541
9023967395	02/54	F	03023
9025293026	12/58	M	24287
9029287062	06/52	F	06061
9029596344	09/55	M	00792
9030165823	12/54	F	05334
9030205973	05/54	M	26411
9030780581	05/29	F	08241
9030861738	10/45	M	01604
9032398914	08/56	M	09760
9032842679	05/59	F	01229
9034248181	10/59	F	07384
9034793801	06/59	F	06468
9035294522	07/58	M	23759
9041726364	07/56	F	03733
9071584167	06/48	M	09604
9104870848	04/67	F	09443
9107346403	08/54	M	08365

MSCommuniqué

Communicating the policy and directives of the Medical Services Commission of British Columbia

Volume 8, Number 3

October 22, 2003

CMQ03-009

Approval of Guideline: Investigation and Management of Vitamin B_{12} and Folate Deficiency

Minute of Commission 03-040

Approval of Guideline:

Investigation and Management of Vitamin B_{12} and Folate Deficiency

Pursuant to Section 5(1)(c), 24(1), and Section 37 of the *Medicare Protection Act,* the following guideline will apply with respect to the Medical Services Commission Payment Schedule:

Investigation and Management of Vitamin B_{12} and Folate Deficiency

This guideline will be used in determination of benefits payable under the *Medicare Protection Act.*

Effective July 1, 2003

CMQ03-010

Approval of Guideline: Heart Failure Care

Minute of Commission 03-050

Approval of Guideline:

Heart Failure Care

Pursuant to Section 5(1)(c), 24(1), and Section 37 of the *Medicare Protection Act,* the following guideline will apply with respect to the Medical Services Commission Payment Schedule:

Heart Failure Care

This guideline will be used in determination of benefits payable under the *Medicare Protection Act.*

Effective November 1, 2003

Members:

Joy Illington (Chair)
Geoff Rowlands (Deputy Chair)
Anne Sutherland Boal
Bob Cronin
Dr. Marshall Dahl
Gordon Denford
George Edgson
Dr. Derryck Smith
Ben Trevino

Guidelines and protocols can be obtained by contacting MSP at 250 952-1347 or by faxing 250 952-1417. Guidelines and protocols are also posted on the MSP web site: http://www.healthservices.gov.bc.ca/msp/protoguides. Please e-mail your questions or comments to hlth.guidelines@gems6.gov.bc.ca

Medical Services Commission of British Columbia, 3-1, 1515 Blanshard Street, Victoria, B.C., V8W 3C8
Telephone: 250 952-3109 • Fax: 250 952-2992

Chronic Disease Management

Diabetes Management

Results from the Vancouver Island Patient Survey

Conducted in the Summer 2002

A survey was conducted in the summer 2002 of patients living on Vancouver Island who had received services related to diabetes from their family doctors or in hospital. The questionnaire was designed by a team from the Ministry of Health Services, Canadian Diabetes Association, and Vancouver Island Health Authority. The survey included questions about accessing information and services, monitoring, self-management activities and complications (see attached).

Profile of Respondents

The questionnaire was mailed to 2,057 people living on Vancouver Island on June 14, 2002. The names of these people were randomly selected from physician billing data where a minimum of two office visits for diabetes mellitus were recorded in the past year, or hospital separation due to a visit related to diabetes was billed to the Medical Services Plan (MSP). Reminder cards were sent on July 30, 2002. Of the 2,057 questionnaires mailed out, 165 questionnaires were undeliverable due to wrong address or death. A total of 985 completed questionnaires were returned - a 52% response rate.

If respondents answered "no" or "don't know" to having ever been told they have diabetes they were eliminated from the analysis. Similarly if respondents indicated they had only had gestational diabetes their questionnaires were not included in the analysis.

A total of 828 respondents indicated on their questionnaire that they currently have diabetes. Thirty-four questionnaires were not included in the analysis due to lack of information. The results are, therefore, based on a final sample size of 794 respondents. The reported percentages are accurate within 3 percentage points 95 times out of 100, including results by region (with an approximate sample size of 250 each).

Overall, 51% of respondents were male. Of the respondents indicating their type of diabetes, 14% had Type 1 diabetes, 78% had Type 2, and 9% were not sure. The majority (96%) had diabetes for over one year, with 37% indicating they had diabetes for 11 or more years. Approximately 57% said they used pills to help manage their diabetes, 18% used insulin injections, and 8% did not use either pills or injections (insulin).

About 66% of respondents were between 45-74 years of age, the majority of which had Type 2 diabetes. Only 6% of respondents were under 45 years of age, while 28% of respondents were 75+ years of age. Thirty percent of respondents had less than grade 11 education; 15% had university or above.

<u>Regional Differences</u>

Regions varied significantly from each other with respect to distribution of age and education, but not gender. The South Island reported having the highest proportion of older and more educated respondents and the highest percentage of respondents with Type 1 diabetes (16%) compared to approximately 10% in the Central and North Island regions. In contrast, the proportion of respondents with Type 2 diabetes increased from south to north: 74%, 81% and 86%, respectively.

Information and Services

The most common sources of information about diabetes were the family doctor, a diabetes education center (DEC) and the Canadian Diabetes Association. Over half (58%) of the respondents indicated they had been to a DEC within the past two years. The majority (78%) of respondents sought information on diabetes from two or more sources. Almost all (99%) respondents reported having a family physician, and were able to get an appointment when needed (97%). Only 10 respondents reported that they usually go to walk-in clinics because they do not have a family doctor. Many more respondents indicated they were very (58%) or somewhat (28%) satisfied with the health care services available in their community, compared to those who indicated they were very (2%) or somewhat (6%) dissatisfied.

- *"In my experience, my pharmacist is the most accessible health professional."*
- *"Speaking with the dietician at the Education Centre helped me the most."*
- *"Education and access to latest information and medications helps me manage."*

Regional Differences

Statistically significant differences were reported across the regions regarding use of Diabetes Education Centres (DEC). South Island respondents reported lower percentages of having ever visited a DEC. Overall, 92% of Central and North Islanders and 84% of South Islanders reported having at any time visited a DEC. This difference was significant even when controlling for age and education. Among those who had visited a DEC, there was a significant variation by region in time since last visit, with the Central and North Islanders more likely to have been to a DEC within the last year.

Monitoring

Ongoing monitoring is an important aspect of managing diabetes. A number of lab tests should be done regularly to check blood sugar control, blood lipids and kidney function. A key test is the hemoglobin A1c (HbA1c), a blood test that indicates the average blood sugar levels over the previous three months. This test should be done two to four times a year.

Overall, 81% of respondents reported having this test done regularly. Two thirds (67%) reported that their doctor indicated their last HbA1c test was ≤.07 (in the normal range), 31% reported their HbA1c was >.07 (above normal). The most common reasons for not having this test done were that the doctor didn't order it, and time/inconvenience.

- *"More information should be circulated to diabetics regarding new products, systems and monitoring."*
- *"My log book agrees with my quarterly HbA1c tests."*
- *"Why don't GPs keep glucose testing equipment in their offices for a quick check before referring for lab tests?"*

Self-Management

Eating healthy foods, exercising and monitoring blood sugars are important aspects of self-management for people with diabetes. Overall, 83% of respondents followed a healthful eating plan at least five days per week during the last month, while 70% ate five or more servings of fruits and vegetables at least five days a week. Only 6% ate high fat foods on five or more days a week.

- *"I have learned from my eating and exercise habits what I can expect my blood sugar to be."*
- *"I can't afford to eat right; I know what my [blood sugar] levels are."*
- *"Once I realized what the problem was I put myself on regular exercise, small meals, and took up yoga."*
- *"Sometimes if blood sugar is high I will exercise to bring it down."*

At least 20 minutes of exercise three times a week is a level often recommended as a minimum target for achieving health benefits for the general population. About 75% of respondents participated in physical activity for at least 30 minutes at least 3 times per week. About half of respondents (56%) undertook specific exercise sessions (such as swimming, walking and biking) at least 3 times a week.

A self-management strategy specific to diabetes is the measurement of blood glucose. Using a finger prick to draw a drop of blood and a glucometer, each person can test their blood sugar at home. A high or low reading is an indicator for patients to alter their diet, exercise or medication. Almost half of island respondents (49%) reported testing their blood sugar daily by finger prick and glucometer. A total of 76% reported that their blood sugar test results gave them the necessary guidance to modify their behaviour– if they had a high reading they would exercise, change their diet or adjust their medication. Among the half of respondents who cited barriers, the cost of glucose monitoring strips was the most commonly reported (36%), followed by "not recommended by doctor/nurse" (31%).

Logbooks or diaries are a useful way to keep track of blood sugars, medications and appointments. About 76% of respondents said they use a logbook either regularly (56%) or sometimes (20)%. Among the nearly quarter of the respondents who did not use a logbook or diary, only 23% reported that their doctor suggested using one. Only 10% of respondents had smoked in the previous week but 71% had a flu shot in the past year. About half of all respondents (51%) reported checking their feet daily, while 14% never check their feet. Only 22% check their shoes daily and almost half, 49% never inspect their shoes.

- *"Wish test strips didn't cost so much."*
- *"I have my blood sugar well under control and just check it periodically."*
- *"Cost of strips is truly a challenge."*

Regional Differences

Geography did not seem to affect overall scores for the questions on patient self-management for exercise and eating plans. However, regions differed significantly in terms of doctors or nurses not recommending patients test their blood sugars, with more South Islanders not receiving this recommendation (19%) compared to North Islanders (10%). While regional differences were not significant, a higher percent of North Islanders (83%) reported using their blood sugar test results for guidance either daily or most of the time, followed by Central Islanders (79%) then South Islanders (72%).

Among the subset of respondents who reported not testing their blood sugar daily, the cost of strips was identified as the main reason - most frequently by North Islanders (50%), then by Central Islanders (42%) and South Islanders (30%). When age and education were controlled, the cost of strips by region was not statistically significant. There was, however, significant variation by region for respondents receiving support from family and friends (9% South; 11% Central; 4% North) before and after controlling for age and education.

- *"Find medication, insulin and test strips very expensive to keep my diabetes at a safe level so I won't have to be more expense to the medical system."*
- *"I don't always manage it I prefer to pretend it is not there!"*
- *"Encouragement of family doctor as a joint partnership [helps me manage]."*

Complications

Diabetes can lead to a number of complications such as foot ulcers, heart and kidney problems. A large number of respondents across the island had a number of complications in addition to diabetes, including high blood pressure (50%), high cholesterol (35%) and problems with eyesight (31%). People with chronic diseases are at higher risk when flu strikes, and flu vaccination programs annually target those at higher risk. While not statistically different, more South Islanders (73%) had a flu shot than Central (68%) and North Islanders (63%).

- *"I never had any symptoms of diabetes. It was a routine eye exam that alerted my doctor."*
- *"Just plain sick all the time."*

Summary

Overall, respondents were quite motivated to monitor their diabetes. Three quarters of respondents used their blood sugar test results to alter their diet or exercise regime. The same proportion of respondents exercised three times per week and followed a healthful eating plan. About 76% of respondents indicated they use a diary or log book to keep track of blood sugars, medications, appointments and adverse reactions.

The biggest barriers identified by respondents were the cost of testing strips and lack of instruction/direction from their health care provider. Among respondents who did not test daily, one half of North Islanders said cost of testing strips was a barrier for daily testing. One third of South Islanders indicated their doctor did not recommend daily blood sugar testing; however about 50% of respondents indicated they do this test daily.

BRITISH COLUMBIA

The Medical Services Plan, in partnership with the Vancouver Island Health Authority, is surveying people who have received medical services related to diabetes. We are asking you to fill out this short survey to help us identify ways to improve care and education for people with diabetes. Please take the time to answer these questions and return the form to us by mail or fax. If you would like help completing the form, please call 952-1319 and a staff member will help you.

1. Has a doctor ever told you, you have diabetes? ❑ Yes ❑ No ❑ Yes, but only during pregnancy

2. Do you have diabetes now?
   - ❑ Yes →
     - ❑ Type 1? → Go to Question 3
     - ❑ Type 2? → Go to Question 3
     - ❑ I'm not sure what type of diabetes I have → Go to Question 3
     - ❑ Gestational diabetes (pregnancy-related only)
   - ❑ No
   - ❑ Don't know

If you answered, No, Don't know, or Gestational diabetes, please return the questionnaire now, and thanks for your help!

3. How many years have you had diabetes? ❑ <1 yr ❑ 1-5 yrs ❑ 6-10 yrs ❑ 11 yrs or more

4. If you have received information about diabetes, where did you get the information? (Please check all that apply)
   - ❑ My family doctor
   - ❑ My diabetes specialist (e.g. internist, endocrinologist)
   - ❑ The Diabetes Education Centre (DEC) (includes diabetes nurse and dietician at DEC)
   - ❑ Internet/ website
   - ❑ Friends / family
   - ❑ TV/magazines/newspaper
   - ❑ Canadian Diabetes Association (CDA)
   - ❑ Other, please specify _____

5. What medications do you take to help manage your diabetes? ❑ pills ❑ injections ❑ none

Hemoglobin A_{1c} (HbA_{1c}) is a blood test used to measure blood sugar levels over the previous three months. This test is done in a lab and isn't done at home.

6. Tthe result of your last hemoglobin A_{1c} blood test was: (Please check all that apply)
   - ❑ Less than 0.07 (or <7%)
   - ❑ 0.07 (or 7%)
   - ❑ 0.08 (8%) or higher
   - ❑ My doctor said it was normal or good
   - ❑ My doctor said it was high
   - ❑ Don't know, or I haven't had it tested
   - ❑ The actual value of my last HbA_{1c} blood test was _____

7. What stops you from getting hemoglobin A_{1c} (HbA_{1c}) tests done regularly? (Check all that apply)
   - ❑ Nothing, I have these tests regularly
   - ❑ I don't have a regular doctor
   - ❑ My doctor doesn't order the tests
   - ❑ Time / Inconvenient to go to the lab
   - ❑ Pain
   - ❑ Other, please specify _____

The questions below ask you about your diabetes self-care activities during the past 7 days. If you were sick or injured during the past 7 days, please think back to the last 7 days when you were not sick or injured.

Diet

8. On how many of the last SEVEN DAYS have you followed a healthful eating plan?

   0 1 2 3 4 5 6 7

9. On average, over the past month, how many DAYS PER WEEK have you followed your eating plan?

   0 1 2 3 4 5 6 7

10. On how many of the last SEVEN DAYS did you eat five or more servings of fruits and vegetables?

    0 1 2 3 4 5 6 7

11 On how many of the last SEVEN DAYS did you eat high fat foods such as hamburgers or full-fat dairy products?

   0 1 2 3 4 5 6 7

Exercise

12. On how many of the last SEVEN DAYS did you participate in at least 30 minutes of physical activity? (Total minutes of continuous activity, including walking).

    0 1 2 3 4 5 6 7

13. On how many of the last SEVEN DAYS did you participate in a specific exercise session (such as swimming, walking, biking) other than what you do around the house or as part of your work?

    0 1 2 3 4 5 6 7

Blood Sugar Testing

14. On how many of the last SEVEN DAYS did you test your blood sugar (finger prick and glucometer)?

    0 1 2 3 4 5 6 7

15 On how many of the last SEVEN DAYS did you test your blood sugar the number of times recommended by your health care provider?

   0 1 2 3 4 5 6 7 ☐ Don't have a recommendation

Foot Care

16. On how many of the last SEVEN DAYS did you check your feet?

    0 1 2 3 4 5 6 7

17. On how many of the last SEVEN DAYS did you inspect the inside of your shoes?

    0 1 2 3 4 5 6 7

18. Have you smoked a cigarette—even one puff—during the past SEVEN DAYS?
- ❑ Yes *If yes*, how many cigarettes did you smoke on an average day?
  - ❑ Number of cigarettes: _____
- ❑ No

19. Have you had a flu shot (influenza vaccination) in the last 12 months?
- ❑ Yes ❑ No ❑ Don't know

20. Do you use a diary (log book) to keep track of blood sugars, medications, appointments, etc.?
- ❑ Yes
- ❑ Sometimes
- ❑ No If no, has your doctor ever suggested you start using a diary? ❑ Yes
- ❑ No

21. *Is there something that stops you from testing your blood sugar every day (finger prick & glucometer)?*
- ❑ Nothing, I do it every day
- ❑ Do not find the information useful
- ❑ Not recommended by my doctor or nurse
- ❑ Cost of strips
- ❑ Time
- ❑ Too much trouble
- ❑ I didn't know I was supposed to test it daily
- ❑ I don't want to
- ❑ Other _____

22. Do you use the results of your blood sugar test (finger prick & glucometer) to change what you eat, how much you exercise, or to adjust your medication?
- ❑ Don't test my blood sugar
- ❑ Yes, every day
- ❑ Yes, most times
- ❑ No, it's too much trouble
- ❑ No, I don't want to
- ❑ Don't know
- ❑ Other _____

23. What health complications do you have in addition to diabetes?
- ❑ High cholesterol
- ❑ Heart problems
- ❑ Problems with eye sight
- ❑ Kidney problems
- ❑ Problems with blood circulation in my feet and/or hands
- ❑ High blood pressure (My most recent blood pressure reading was _____(i.e. 160/90)
- ❑ Other, please specify _____

24. When did you last go to a Diabetes Education Center (DEC)?
- ❑ Never
- ❑ <1 yr ago
- ❑ 1-2 yrs ago
- ❑ 3-4 years ago
- ❑ 5 or more years ago

25. Do you have a family doctor?
- ❑ Yes
- ❑ No If no, why not? (check all that apply)
  - ❑ I usually go to Walk-in Clinics
  - ❑ I can't find a regular family doctor
  - ❑ Transportation is a problem
  - ❑ Other (please specify)_____

26. If you have a regular family doctor, can you generally get an appointment when you need it?
- ❑ Yes
- ❑ No If no, why not _____

27. Overall, how satisfied are you with the health care services available in your community that support you living with diabetes?

❑ Very satisfied ❑ Somewhat satisfied ❑ Somewhat dissatisfied ❑ Very dissatisfied ❑ Don't know / unsure

28. What helps you the most in managing your diabetes?

_____

_____

_____

29. *Please choose your age group:*
- ❑ under 25 years old
- ❑ 25-34 years old
- ❑ 35-44 years old
- ❑ 45-54 years old
- ❑ 55-64 years old
- ❑ 65-74 years old
- ❑ 75-84 years old
- ❑ 85 years old and over

30. Are you:
- ❑ Male
- ❑ Female

31. What is the highest level of education you have **completed**? (Please check only one)
- ❑ Grade 8 or lower
- ❑ Grade 9-10
- ❑ Grade 11-13 (including GED–General Education Diploma)
- ❑ Trades certificate, vocational school diploma, apprenticeship
- ❑ Non-university certificate below Bachelor's level
- ❑ Bachelor's degree
- ❑ University degree, certificate or diploma above Bachelor's degree

32. Please feel free to attach any other comments.

Thank you for taking the time to answer and return these questions!

Please use the enclosed envelope to mail this questionnaire to:

Medical Services Plan
Ministry of Health Services
PO Box 9999 Stn Prov Govt
Victoria BC V8W 9W9